VERMONT

DOL FORM 8 (Rev. 5/05)

State File No. _____

Ins. Co. File No. _____

Date of Injury _____

Fed. ID No. _____

DEPARTMENT OF LABOR
WORKERS' COMPENSATION DIVISION

NOTICE OF INTENT TO CHANGE HEALTH CARE PROVIDER

NOTE: An employee has the right to change health care providers from the one suggested or assigned to them by their employer, **regardless** of the reasons for the change, at **any time** during the course of treatment after the first appointment.

EMPLOYEE NAME: _____ SOCIAL SECURITY NO.: _____

ADDRESS: _____

CITY/STATE: _____ TELEPHONE: _____

I am changing my medical care for my work-related injury from the first treating health care provider selected by my employer to the provider of my choice.

FIRST TREATING PROVIDER:

NAME: _____

ADDRESS: _____

CITY/STATE: _____

NEW TREATING PROVIDER:

NAME: _____

ADDRESS: _____

CITY/STATE: _____

I am changing because:

- ☐ I would rather treat with my family health care provider.
- ☐ I believe another health care provider is better able to treat my symptoms.
- ☐ I have previously treated with another health care provider.
- ☐ Other (please describe below):

_____

_____

This notice should be presented to the employer/insurance carrier prior to changing health care providers to fulfill the requirements of Vermont law, (21 V.S.A. § 640(b)). Notice is not required for subsequent changes of provider after the first change of provider form is submitted.

_____
Print Employee Name

_____ _____
Employee Signature Date